Billing Procedures (Pharm)

Last Updated: 05/25/2022

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Updated: 10/1/2017

The purpose of this chapter is to explain the documentation procedures for billing the Virginia Medicaid Program.

Two major areas are covered in this chapter:

- **General Information** - This section contains information about the timely filing of claims, claim inquiries, and supply procedures.
- **Billing Procedures** - Instructions are provided on the completion of claim forms, submitting adjustment requests, and additional payment for services.

Electronic Submission of Claims

Electronic billing is a fast and effective way to submit Medicaid claims. Claims will be processed faster and more accurately because electronic claims are entered into the claims processing system directly. For more information contact our fiscal agent, Conduent:

Phone: (866)-352-0766
Fax number: (888)-335-8460
Conduent's Website: https://www.virginiamedicaid.dmas.virginia.gov or by mail

Conduent
EDI Coordinator
Virginia Medicaid Fiscal Agent
P.O. Box 26228
Richmond, Virginia 23260-6228

Billing Instructions: Direct Data Entry

As part of the 2011 General Assembly Appropriation Act - 300H which requires that all new providers bill claims electronically and receive reimbursement via Electronic Funds Transfer (EFT) no later than October 1, 2011 and existing Medicaid providers to transition to electronic billing and receive reimbursement via EFT no later than July 1, 2012, DMAS has implemented the Direct Data Entry (DDE) system. Providers can submit claims quickly and easily via the Direct Data Entry (DDE) system. DDE will allow providers to submit Professional (CMS-1500), Institutional (UB-04) and Medicare Crossover claims directly to DMAS via the Virginia Medicaid Web Portal. Registration thru the Virginia Medicaid Web Portal is required to access and use DDE. The DDE User Guide, tutorial and FAQs can be accessed from our web portal at: www.virginiamedicaid.dmas.virginia.gov. To access the DDE system, select the Provider Resources tab and then select Claims Direct Data Entry (DDE). Providers have the ability to create a new initial claim, as well as an adjustment or a void through the DDE process. The status of the claim(s) submitted can be checked the next business day if claims

were submitted by 5pm. DDE is provided at no cost to the provider.

Timely Filing

The Medical Assistance Program regulations require the prompt submission of all claims. Virginia Medicaid is mandated by federal regulations [42 CFR § 447.45(d)] to require the initial submission of all claims (including accident cases) within 12 months from the date of service. Providers are encouraged to submit billings within 30 days from the last date of service or discharge. Federal financial participation is not available for claims, which **are not** submitted within 12 months from the date of the service. Submission is defined as actual, physical receipt by DMAS. In cases where the actual receipt of a claim by DMAS is undocumented, it is the provider's responsibility to confirm actual receipt of a claim by DMAS within 12 months from the date of the service reflected on a claim. If billing electronically and timely filing must be waived, submit the DMAS-3 form with the appropriate attachments. The DMAS-3 form is to be used by electronic billers for attachments. (See Exhibits) Medicaid is not authorized to make payment on these late claims, except under the following conditions:

Retroactive Eligibility - Medicaid eligibility can begin as early as the first day of the third month prior to the month of application for benefits. All eligibility requirements must be met within that time period. Unpaid bills for that period can be billed to Medicaid the same as for any other service. If the enrollment is not accomplished in a timely way, billing will be handled in the same manner as for delayed eligibility.

Delayed Eligibility - Medicaid may make payment for services billed more than 12 months from the date of service in certain circumstances. Medicaid denials may be overturned or other actions may cause eligibility to be established for a prior period. Medicaid may make payment for dates of service more than 12 months in the past when the claims are for an enrollee whose eligibility has been delayed. It is the provider's obligation to verify the patient's Medicaid eligibility. Providers who have rendered care for a period of delayed eligibility will be notified by a copy of a letter from the local department of social services which specifies the delay has occurred, the Medicaid claim number, and the time span for which eligibility has been granted. The provider must submit a claim on the appropriate Medicaid claim form within 12 months from the date of the notification of the delayed eligibility. A copy of the "signed and dated" letter from the local department of social services indicating the delayed claim information must be attached to the claim.

Denied claims – Denied claims must be submitted and processed **on or before thirteen months from date of the initial denied claim where the initial claim was filed within the 12 months limit to be** considered for payment by Medicaid. The procedures for resubmission are:

- Complete invoice as explained in this billing chapter.
- **Attach** written documentation to justify/verify the explanation. This documentation may be continuous denials by Medicaid or any dated follow-up correspondence from Medicaid showing that the provider has actively been submitting or contacting

Medicaid on getting the claim processed for payment. Actively pursuing claim payment is defined as documentation of contacting DMAS at least every six months. Where the provider has failed to contact DMAS for six months or more, DMAS shall consider the resubmission to be untimely and no further action shall be taken. If billing electronically and waiver of timely filing is being requested, submit the claim with the appropriate attachments. (The DMAS-3 form is to be used by electronic billers for attachments. See exhibits).

Accident Cases - The provider may either bill Medicaid or wait for a settlement from the responsible liable third party in accident cases. However, all claims for services in accident cases must be billed to Medicaid within 12 months from the date of the service. If the provider waits for the settlement before billing Medicaid and the wait extends beyond 12 months from the date of the service, Medicaid shall make no reimbursement.

Other Primary Insurance - The provider should bill other insurance as primary. However, all claims for services **must be billed to Medicaid within 12 months from the date of the service.** If the provider waits for payment before billing Medicaid and the wait extends beyond 12 months from the date of the service, Medicaid shall make no reimbursements. If payment is made from the primary insurance carrier after a payment from Medicaid has been made, an adjustment or void should be filed at that time.

Other Insurance - The member can keep private health insurance and still be covered by Medicaid or FAMIS Plus. The other insurance plan pays first. Having other health insurance does not change the co-payment amount that providers can collect from a Medicaid member. For members with a Medicare supplemental policy, the policy can be suspended with Medicaid coverage for up to 24 months while the member has Medicaid without penalty from their insurance company. The members must notify the insurance company. The member must notify the insurance company within 90 days of the end of Medicaid coverage to reinstate the supplemental insurance.

Submit the claim in the usual manner by mailing the claim to billing address noted in this chapter.

Billing Instructions: Automated Crossover Claims Processing (DME)

Most claims for dually eligible members are automatically submitted to DMAS. The Medicare claims processor will submit claims based on electronic information exchanges between these entities and DMAS. As a result of this automatic process, the claims are often referred to as “crossovers” since the claims are automatically crossed over from Medicare to Medicaid.

To make it easier to match providers to their Virginia Medicaid provider record, providers are to begin including their Virginia Medicaid ID as a secondary identifier on the claims sent to Medicare. When a crossover claim includes a Virginia Medicaid ID, the claim will be processed by DMAS using the Virginia Medicaid number rather than the Medicare vendor number. This will ensure the appropriate Virginia Medicaid provider is reimbursed.

When providers send in the 837 format, they should instruct their processors to include the Virginia Medicaid provider number and use qualifier “1D” in the appropriate reference (REF) segment for provider secondary identification on claims. Providing the Virginia Medicaid ID on the original claim to Virginia Medicaid will reduce the need for submitting follow-up paper claims.

DMAS has established a special email address for providers to submit questions and issues related to the Virginia Medicare crossover process. Please send any questions or problems to the following email address: Medicare.Crossover@dmas.virginia.gov.

Billing Instructions: Electronic Filing Requirements

DMAS is fully compliant with 5010 transactions and will no longer accept 4010 transactions after March 30, 2012.

The Virginia MMIS will accommodate the following EDI transactions according to the specification published in the Companion Guide version 5010

270/271 Health Insurance Eligibility Request/ Response Verification for Covered Benefits (5010)

276/277 Health Care Claim Inquiry to Request/ Response to Report the Status of a Claim (5010)

277 - Unsolicited Response (5010)

820 - Premium Payment for Enrolled Health Plan Members (5010)

834 - Enrollment/ Disenrollment to a Health Plan (5010)

835 - Health Care Claim Payment/ Remittance (5010)

837 - Dental Health Care Claim or Encounter (5010)

837 - Institutional Health Care Claim or Encounter (5010)

837 - Professional Health Care Claim or Encounter (5010)

NCPDP - National Council for Prescription Drug Programs Batch (5010)

NCPDP - National Council for Prescription Drug Programs POS (5010) Although not mandated by HIPAA, DMAS has opted to produce an Unsolicited 277 transaction to report information on pended claims.

All 5010/D.0 Companion Guides are available on the web portal: https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/EDICompanionGuides or contact EDI Support at 1-866-352-0766 or Virginia.EDISupport@conduent.com.

Although not mandated by HIPAA, DMAS has opted to produce an Unsolicited 277 transaction to report information on pended claims.

For providers that are interested in receiving more information about utilizing any of the above electronic transactions, your office or vendor can obtain the necessary information at our fiscal agent's website: https://www.virginiamedicaid.dmas.virginia.gov.

Billing Instructions: ClaimCheck

- Effective June 3, 2013, DMAS implemented the Medicaid National Correct Coding Initiative (NCCI) Procedure to Procedure (PTP) and Medically Unlikely Edits

(MUE) edits. This implementation was in response to directives in the Affordable Care Act of 2010. These new edits will impact all Physicians, Laboratory, Radiology, Ambulatory Surgery Centers, and Durable Medical Equipment and Supply providers. Effective January 1, 2014, all outpatient hospital claims will be subject the the NCCI edits thru the EAPG claim processing. Please refer to the Hospital Manual, Chapter 5 for details related to EAPG. The NCCI/ClaimCheck edits are part of the daily claims adjudication cycle on a concurrent basis. The current claim will be processed to edit history claims. Any adjustments or denial of payments from the current or history claim(s) will be done during the daily adjudication cycle and reported on the providers weekly remittance cycle. All NCCI/ClaimCheck edits are based on the following global claim factors: same member, same servicing provider, same date of service or the date of service is within established pre- or post-operative time frame. All CPT and HCPCS code will be subject to both the NCCI and ClaimCheck edits. Upon review of the denial, the provider can re-submit a corrected claim. Any system edits related to timely filing, etc. are still applicable.

- PTP Edits:

CMS has combined the Medicare Incidental and Mutually Exclusive edits into a new PTP category. The PTP edits define pairs of CPT/HCPCS codes that should not be reported together. The PTP codes utilize a column one listing of codes to a column two listing of codes. In the event a column one code is billed with a column two code, the column one code will pay, the column two code will deny. The only exception to the PTP is the application of an accepted Medicaid NCCI modifier. **Note**: Prior to this implementation, DMAS modified the CCI Mutually Exclusive edit to pay the procedure with the higher billed charge. This is no longer occurring, since CMS has indicated that the code in column one is to be paid regardless of charge.

- MUE Edits:

DMAS implemented the Medicaid NCCI MUE edits. These edits define for each CPT/HCPCS code the maximum units of service that a provider would report under most circumstances for a single member on a single date of service and by same servicing provider. The MUEs apply to the number of units allowed for a specific procedure code, per day. If the claim units billed exceed the per day allowed, the claim will deny. With the implementation of the MUE edits, providers must bill any bilateral procedure correctly. The claim should be billed with one unit and the 50 modifier. The use of two units will subject the claim to the MUE, potentially resulting in a denial of the claim. Unlike the current ClaimCheck edit which denies the claim and creates a claim for one unit, the Medicaid NCCI MUE edit will deny the entire claim.

- Exempt Provider Types:

DMAS has received approval from CMS to allow the following provider types to be exempt from the Medicaid NCCI editing process. These providers are: Community Service Boards (CSB), Federal Health Center (FQHC),Rural Health Clinics (RHC), Schools and Health Departments. These are the only providers exempt from the NCCI/editing process. All other providers billing on the CMS 1500 will be subject to these edits.

- Service Authorizations:

DMAS has received approval from CMS to exempt specific CPT/HCPCS codes which require a valid service authorization. These codes are exempt from the MUE edits however, they are still subject to the PTP and ClaimCheck edits.

- Modifiers:

Prior to this implementation, DMAS allowed claim lines with modifiers 24, 25, 57, 59 to bypass the CCI/ClaimCheck editing process. With this implementation, DMAS now only allows the Medicaid NCCI associated modifiers as identified by CMS for the Medicaid NCCI. The modifier indicator currently applies to the PTP edits. The application of this modifier is determined by the modifier indicator of "1"or "0" in the listing of the NCCI PTP column code. If the column one, column two code combination has a modifier indicator of "1", a modifier is allowed and both codes will pay. If the modifier indicator is "0", the modifier is not allowed and the column two code will be denied. The MUE edits do not contain a modifier indicator table on the edit table. Per CMS, modifiers may only be applied if the clinical circumstances justify the use of the modifier. A provider cannot use the modifier just to bypass the edit. The recipient's medical record **must** contain documentation to support the use of the modifier by clearly identifying the significant, identifiable service that allowed the use of the modifier. DMAS or its agent will monitor and audit the use of these modifiers to assure compliance. These audits may result in recovery of overpayment(s) if the medical record does not appropriately demonstrate the use of the modifiers.

Modifiers that may be used under appropriate clinical circumstances to bypass an NCCI PTP edit include: E1 –E4, FA, F1 – F9, TA T1 – T9, LT, RT, LC, LD, RC, LM, RI, 24, 25, 57, 58, 78, 79, 27, 59, 91. Modifiers 22, 76 and 77 are not Medicaid PTP NCCI approved modifiers. If these modifiers are used, they will not bypass the Medicaid PTP NCCI edits.

Reconsideration

Providers that disagree with the action taken by a ClaimCheck/NCCI edit may request a reconsideration of the process via email (ClaimCheck@dmas.virginia.gov) or by submitting a request to the following mailing address:

Payment Processing Unit, Claim Check
Division of Program Operations
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

There is a 30-day time limit form the date of the denial letter or the date of the remittance advice containing the denial for requesting reconsideration. A review of additional documentation may sustain the original determination or result in an approval or denial of additional day(s). Requests received without additional documentation or after the 30-day limit will not be considered.

Billing Instructions Reference for Services Requiring Service Authorization

Please refer to the "Service Authorization" section in Appendix D of this manual.

Billing Instructions: Billing for Pharmacy Services

To bill the Virginia Medicaid Program for pharmaceutical services provided to members, a provider may use the Daily Pharmacy Drug Claim Ledger (DMAS-173 R6/03). For compounded prescriptions, use the Compound Prescription Pharmacy Claim Form (DMAS-174). In the case of home I.V. services or Durable Medical Equipment (DME), which includes nutritional supplements, the CMS-1500 form must be used. Virginia Medicaid encourages pharmacy providers to submit claims for electronic processing whenever possible. Electronic claims must be submitted in NCPDP Version D.0 format.

Providers shall bill the Virginia Medicaid Program their usual and customary charges for all prescriptions dispensed. The Medicaid claims processing system will calculate the reimbursement due according to the rules described in Chapter IV of this manual.

The National Drug Code (NDC) assigned by the manufacturer or distributor found on the package label must be used when billing the Virginia Medicaid Program. Hyphens in an NDC are not recognized in the DMAS processing system.

For a multiple-source drug (VMAC or CMS) with maximum cost reimbursement limits where the physician indicates "Brand Necessary," the NDC identifying the brand-name product dispensed is used, and the DMAS-173 R6/03 requires entry of the number "1" in field 9 DAW. If "Brand Necessary" is not indicated on the prescription, the NDC must identify the less expensive generic product actually dispensed, not the brand-name product.

Co-payment amounts shall be as follows:

- One dollar ($1.00) co-pay for generic drug products; and
- Three dollars ($3.00) co-pay for single source or "Brand Necessary" products.

Billing Instructions: Third Party Liability (TPL) Collections for Point-of-Service (POS) Claims (Pharm)

In order to conserve Medicaid dollars, and as payer of last resort, DMAS is beginning a process of Coordination of Benefits (COB) for Third Party Liability (TPL) collection at the Point-of-Service. For pharmacy claims having a service date on or after June 20, 2003, DMAS will send an online claim denial message to pharmacy providers submitting POS claims for which the patient has other

insurance coverage. The messages used in this project are shown in the table below.

VA Code	Virginia Denial Message Text	NCPDP Code	NCPDP Reject Message Text
313	Bill Any Other Available Insurance	41	Submit Bill To Other Processor Or Primary Payer
387	Primary Carrier Payment Needs Explanation	13	Missing/Invalid Other Coverage Code

DMAS requests that providers receiving either of these messages verify whether the patient has additional coverage. If the patient acknowledges such coverage, the pharmacist should submit the claim first to that third party. Once the other insurer adjudicates the claim, the claim may be resubmitted to DMAS using appropriate messages in NCPDP data element fields, "OTHER COVERAGE CODE" and "OTHER PAYER AMOUNT." These fields are included in existing payer specifications. In order to submit an override to the denial, the pharmacist must use the appropriate response in each field as shown below. In the case where a patient denies having additional coverage, the responses to be used in these fields are also noted below.

The pharmacy TPL editing is based on the NCPDP "Other Coverage Code" standard values (Version D.0). These values and their definitions are as follows:

- 00 - Not specified
- 01 - No other coverage identified
- 02 - Other coverage exists - payment collected
- 03 - Other coverage exists - this claim not covered
- 04 - Other coverage exists - payment not collected
- 05 - Managed care plan denied
- 06 - Other coverage denied - not a participating provider
- 07 - Other coverage exists - not in effect on date of service (DOS)
- 08 - Claim is being billed for co-pay

Below is a grid reflecting the combination of Other Coverage Codes, presence or absence of a third party payment amount, and whether or not the member's record indicates third party pharmacy coverage with the proposed corresponding claim disposition.

Other Coverage Code	*TPL Amt*	*TPL Indicated on Member's Record*	*Initial Claim Disposition*	*Override Process*
Other Coverage Code	*TPL Amt*	*TPL Indicated on Member's Record*	*Initial Claim Disposition*	*Override Process*
0 = Not Specified	0	Yes	Deny, Bill Other Carrier VA code 313/NCPDP code 41	Provider can resubmit with an Other Coverage Code of 3 or 4 as appropriate.

0 = Not Specified	0	No	Pay	
0 = Not specified	>0	Yes or No	Deny, *TPL Indicators Conflict* VA code 387/NCPDP code 13	Provider can resubmit with corrected Other Coverage Code or zeros in TPL Amount.
1 = No other coverage identified	0	Yes	Deny, Bill Other Carrier VA code 313/NCPDP code 41	Provider can resubmit with an Other Coverage Code of 3 or 4 as appropriate.
1 = No other coverage identified	0	No	Pay	
1 = No other coverage identified	>0	Yes or No	Deny, *TPL Indicators Conflict* VA code 387/NCPDP code 13	Provider can resubmit with corrected Other Coverage Code or zeros in TPL Amount.
2 = Other coverage exists, payment collected	0	Yes or No	Deny, *TPL Indicators Conflict* VA code 387/NCPDP code 13	Provider can resubmit with corrected Other Coverage Code and TPL Amount.
2 = Other coverage exists, payment collected	>0	Yes or No	Pay	Payment = Calculated Amount minus Other Payer Amount
3 = Other coverage exists, this claim not covered	0	Yes or No	Pay	This code should be used when the drug is not covered by the other carrier
3 = Other coverage exists, this claim not covered	>0	Yes or No	Deny, *TPL Indicators Conflict* VA code 387/NCPDP code 13	Provider must resubmit with corrected Other Coverage Code if wrong code entered or enter zeros in TPL Amount if Other Coverage Code was entered correctly.
4 = Other coverage exists, payment not collected	>0	Yes or No	Deny, *TPL Indicators Conflict* VA code 387/NCPDP code 13	Provider can resubmit with corrected Other Coverage Code or zeros in TPL Amount.
Other Coverage Code	*TPL Amt*	*TPL Indicated on Member's Record*	*Initial Claim Disposition*	*Override Process*
4 = Other coverage exists, payment not collected	0	Yes or No	Pay	This code should be used when the drug is covered by the other carrier but the pharmacy has not been able to collect from the other resource.
5 = Managed Care Plan Denial	0	Yes	Denial	This code should be used when the drug is not covered by other payer.

6 = Other coverage denied, not participating provider	0
7 = Other coverage exists - Not in effect on date of service	0
8 = Claim is being billed for co-pay	0

If a patient denies having other coverage, the pharmacist should use the appropriate override codes and fill the prescription as if it were a "Pay-and-Chase" claim. Until future notice, such claims will be handled under the "Pay-and-Chase" Waiver. Pharmacists are requested to make every effort to capture TPL payments where possible in order to maximize the potential cost savings to the Medicaid program.

Virginia Medicaid, always the payer of last resort, will only pay claims to the maximum of the Virginia Medicaid Allowed Amount. The coordinated benefit payment of the TPL amount and any additional Medicaid payment will be equivalent to the appropriate payment allowed under DMAS payment rules. Therefore, the total payment may not appear to correspond to the submitted claim amount. The final adjudication under Medicaid will show the appropriate co-pay to be collected from the patient.

For claims submitted using other media, pharmacy providers are requested to attempt to determine if such TPL coverage exists. Using the proprietary format of the DMAS-173 (R6/03), use of fields 23 and 24 will capture the desired elements. This information is mandatory for paper claims submission of TPL claims. Immediate pharmacist participation in this effort will assist in the DMAS cost-savings initiatives.

Billing Instructions: Billing Instructions (Pharm)

The Pharmacy Claim Form, DMAS-173 (R 6/03), will be used for adjustments and voids of pharmacy claims. At the end of the chapter in the “Exhibits” section you will find an example of the Pharmacy Claim Form, DMAS-173 (R 6/03) and Compound Prescription Pharmacy Claim Form, DMAS-174 (R 6/03). Directions for the DMAS-174 appear on the back of the claim form and may also be found in the "Exhibits" section.

The form is printed in "red drop-out" ink which allows it to be processed through a scanner, rather than having to be entered by operators into the system. This format will speed up processing and should improve the timeliness of claims resolution.

Because the scanners operate only when the forms are printed in this special ink, it will not be possible for providers to make copies of the form to be used as substitutes for the supplied forms. Please be sure to order forms from Commonwealth-Martin in adequate time for your needs.
Virginia Department of Medical Assistance Services Pharmacy Claim Form (DMAS-173 R6/03)

Required Fields

Field Number	Description	Required (*)
1	Medicaid Pharmacy Provider Number (9digits)	*
2	Patient's Last Name	*
2a	Patient's First Name	
3	12-digit Medicaid Patient ID	*
4	Patient's Sex M=Male F=Female	*
5	Patient's Birth Date MMDDCCYY	
6	Level of Service	* - only if Emergency **(03)**
7	Days Supply	*
8	New Prescription = **00**; Refill = **01 to 99**	*
9	DAW Codes = 1	*- only if brand dispensed (1)
10	Patient's location	* - only if Nursing Home (03)
11	Resubmit Code	
12	Original Reference Number	
13	Seven-digit Rx Number	*
14	Date Dispensed (MMDDCCYY) (zero fill)	*
15	11-digit NDC of Product Dispensed	*
16	Metric Decimal Quantity - **EG (e.g., 000002.500)**	*
17	Unit Dose Code	* - only if Unit Dose for Nursing Home (4)
18	Service Authorization Medical Certification Code	
Field Number	**Description**	**Required (*)**
19	11-digit Service Authorization Number	
20	Valid Prescriber's Medicaid Provider ID #	*
21	ICD CM Diagnosis Code	
22	Usual & Customary Charge (e.g., 199/09 for $199.09)	*
23	Other Coverage Codes	
24	Dollar Amount Paid by Primary Payer	
25	Dispensing Status. To be used for partial fill prescriptions only. Partial fill = P or Completion of a partial fill = C	*- if needed
26	Intended Metric Quantity to be dispensed. The quantity positions are the same as field 16 (e.g., 000002.500)	*
27	Days' supply corresponding to in-tented metric quantity (#26)	*
28	Prescription number from initial partial fill. Use for completion claim.	
29	Date dispensed from initial partial fill. Use for completion claim.	

30	Comments	
31	Pharmacy name, address, and phone number	*
31	Certification statement, signature, and date	*

Special information for current pharmacy claims submission:

Billing Instructions: Pharmacy Claim Form, DMAS-173 (R06/03)

The Pharmacy Claim Form is designed to be completed for one patient only. Each block on the form must be completed correctly with the required information to receive payment for services provided and to avoid delays in processing the claim. (See the "Exhibits" section at the end of this chapter for a sample of this form.)

The instructions for completing each block on this form are as follows:

Block 1	**Pharmacy ID Number** - Enter the nine-digit provider identification number assigned by the Virginia Medicaid Program (remember to add two leading zeroes).
Block 2 and 2A	Patient's Last Name Patient's First Name
Block 3	**Patient ID Number** - Enter the 12-digit Virginia Medicaid identification number assigned to the member receiving the prescription. This number must be entered exactly as it appears on the Medicaid ID card.
Block 4	Patient's sex **-** M = Male, F = Female.
Block 5	**Date of Birth -** MMDDCCYY (zero fill as necessary, e.g., 06012003)
Block 6	**Level of Service** - Enter level of service if appropriate 01 = Patient Consultation, 02 = Home Delivery, 03 = Emergency, 04 = 24- hour supply, 05 = Patient consultation regarding generic product selection, 06 = In-home Service. At the present time only 03 = emergency is functional. It is to be used in an emergency when a Client Medical Management (CMM) member's designated CMM pharmacy is closed or does not stock the drug.
Block 7	**Days Supply -** Maximum allowable days supply is 34
Block 8	**Refill -** If original enter 00. Refill values 01 to 99.
Block 9	**DAW -** Enter 1 for prescriptions for Brand Medically Necessary as indicated in the prescribing physician's own handwriting in accordance with Virginia law and Medicaid policy. Fraudulent use of the DAW 1 indicator is an auditable offense.

Block 10	**Patient's Location** - NCPDP approved codes include 00 = not specified, 01 = Home, 02 = Inter-Care, 03 = Nursing Home, 04 = Long Term/Extended Care, 05 = Rest Home, 06 = Boarding Home, 07 = Skilled Care Facility, 08 = Sub Acute Care Facility, 09 = Acute Care Facility, 10 = Outpatient, 11 = Hospice. Currently the only functioning location code is 04 = Nursing Home.
Block 11	**Resubmission Code** - use if an adjustment or void is being requested. Codes are 1033 = correcting prescriber ID, 1034 = correcting metric quantity, 1035 = correcting drug code, 1036 = allowance for Rx less than pharmacy cost, (wholesale invoice attached), 1053 = Other, 1052 = Void. This is the only form that will be accepted for adjustments and replaces DMAS 228.
Block 12	**Original Reference Number -** Enter the 16-digit original reference number (ICN) of the claim that is to be adjusted or voided. This field must be completed if field 11 is submitted.
Block 13	**Prescription Number** – Enter nine-digit prescription number. If the claim is a void or adjustment, the prescription number must be the original prescription number.
Block 14	**Date Dispensed -** Enter date as MMDDCCYY (zero fill as necessary - e.g., 10012003)
Block 15	**NDC Code** - Enter the 11-digit National Drug Code (NDC) for the dispensed product.
Block 16	**Metric Quantity** - Enter the metric decimal quantity. The line serves as the decimal point. The areas allows up to six digits before the decimal point (the line on the claim form) and three digits after the decimal point (e.g., 000002.500).
Block 17	**Unit Dose Code -** Values are 0 = Not specified, 1 = Not unit dose, 2 = Manufacturer's unit dose, 3 = Pharmacy Unit Dose, 4 = Unit Dose for Nursing Homes.
Block 18	**Service Authorization Medical Certification Code** - Valid codes are 0 = Not specified, 1 = Service Authorization, 2 = Medical Certification, 3 = EPSDT, 4 = Exemption from Co-pay, 5 = Exemption from prescription limits, 6 = Family planning indicator, 7 = AFDC, 8 = Payer-defined exemption.
Block 19	**Service Authorization Number** - Enter 11-digit service authorization number.
Block 20	**Prescriber's Medicaid ID Number** - Enter the nine-digit Medicaid provider number. **A valid number must be entered for payment to be approved. Use of the unknown prescriber numbers will be audited, and payment will be revoked when an unknown number is entered for a valid prescriber.**
Block 21	**Diagnosis -** Enter ICDCM diagnosis code if applicable. Do not enter decimal point.

Block 22 **Amount Billed** - Enter usual and customary charge for prescription, including dispensing fee. Line serves as decimal point
(eg., 199/09 for $199.09).

Block 23 **Other Coverage Code** - Coordination of benefits can be billed online with the appropriate NCPDP coding information. Valid codes include: 00 = Not specified, 01 = No other coverage exists, 02 = Other coverage exists and payments have been collected, 03 = Other coverage exists - claim not covered, 04 = Other coverage exists - payment not collected, 05 = Managed Care plan denied, 06 = other coverage denied - not a participating provider, 07 = Other coverage exists - not in effect on date of service, 08 = Claim being billed for co-pay.

Block 24 **Payment by Primary Carrier** - Enter payment by other carrier. Line serves as decimal point (e.g., 299/09 = $299.09).

Block 25 **Dispense Status -** Partial and Complete fills. This field is only required for partial prescription fills. Enter P for partial or C for complete. This field should not be used when dispensing full prescriptions for the intended quantity.

Block 26 **Quantity intended to be dispensed -** Enter prescription quantity as Prescribed by physician. Line serves as decimal point.

Block 27 **Intended Days' Supply** - Enter days supply as prescribed by Physician.

Block 28 **Prescription Number from the Initial Partial Fill Claim** - When submitting a completion 'C' claim, enter in field 28 the prescription number from the initial partial fill claim.

Block 29 **Date Dispensed from the Initial Partial Fill Claim** - When submitting the completion 'C' claim, enter in field 29 the date dispensed from the initial partial fill claim.

Block 30 **Comments** - Enter comments, if any (e.g., claim #3 used for high cholesterol).

Block 31 **Pharmacy Contact Information** - Enter the Pharmacy's name, address, and telephone number.

Block 32 **Certification Statement** - Note the certification statement on the claim form, then sign and date the claim form.

Billing Instructions: Pharmacy Claim Form, DMAS-174 (R06/03)

The Compound Prescription Pharmacy Claim Form is designed to be completed for one patient only. Each block on the form must be completed correctly with the required information to receive payment for services provided and to avoid delays in processing the claim. (See the "Exhibits" section at the end of this chapter for a sample of this form.)

The instructions for completing each block on this form are as follows:

Block 1	The Resubmission Code is only used if an adjustment or void is being requested. Enter the appropriate code if requesting the adjustment or void. Valid values are 1033 = Correcting prescriber ID, 1034 = Correcting metric quantity, 1035 = correcting drug code, 1036 = Allowance for Rx less than pharmacy cost, (wholesale invoice attached), 1053 = Other, 1052 = Void.
Block 2	The Original Reference Number is only used if an adjustment or void is being requested. Enter the 16 digits of the original claim reference number (ICN) of the claim that is to be adjusted or voided. This field must be filled if a code is in field 1.
Block 3	Leave blank.
Block 4	Enter your nine-digit Medicaid provider ID number. Do not use zeros with slashes.
Block 5	Enter the level of service code if appropriate. 01 = Patient consultation, 02 = Home delivery, 03 = Emergency, 04 = 24-hour service, 05 = Patient consultation regarding generic product selection, 06 = In-home service.
Block 6	Enter the ICD-CM diagnosis code if appropriate. If using a four- or five-digit code number, do not enter the decimal point.
Block 7	Service Authorization Medical Certification code, (PAMC). Valid codes are: 0 = Not specified, 1 = Service Authorization, 2 = Medical certification, 3 = EPSDT, 4 = Exemption from Co-pay, 5 = Exemption from prescription limits, 6 = Family planning indicator, 7 = AFDC, 8 = Payer-defined exemption.
Block 8	Enter the 11-digit service authorization number.
Block 9	Enter the 12-digit Medicaid Patient ID number.
Block 10	Enter the patient's last name and first name in the appropriate boxes.

Block 11	Enter the patient's sex - M = Male, F = Female
Block 12	Enter the patient's birth date. Use MMDDCCYY format. Zero fill as appropriate (e.g., 06012003).
Block 13	Enter the prescriber's Medicaid provider ID number. Do not use zeros with slashes.
Block 14	Enter the prescription's seven-digit Rx number. If this claim is for an adjustment or void, the Rx number must be the original Rx number on the claim being adjusted or voided.
Block 15	Enter the date dispensed in MMDDCCYY format. Zero fill as appropriate (e.g., 10012003).
Block 16	Enter the days' supply.
Block 17	If this is an original prescription, enter 00. Refill values are 01 to 99.
Block 18	Enter the patient's location. Valid values are 00 = Not specified, 01 = Home, 02 = Inter-Care, 03 = Nursing Home, 04 = Long Term/Extended Care, 05 = Rest Home, 06 = Boarding Home, 07 = Skilled Care Facility, 08 = Sub Acute Care Facility, 09 = Acute Care Facility, 10 = Outpatient, 11 = Hospice.
Block 19	Enter the 11-digit National Drug Code (NDC). Be certain all NDC's entered are current.
Block 20	Enter the Dispense as Written, (DAW) override code of "1" for prescriptions for which "Brand Necessary" is indicated in accordance with the law and Medicaid policy. The value should be used only when the prescribing physician certifies "Brand Necessary" in his or her own handwriting for a prescribed brand- name drug that is generically available.
Block 21	Description or Drug Name of ingredient.
Block 22	Indicate the metric decimal quantity (e.g., 000002.500) of product using the appropriate unit of measure (each, gram, or milliliter).
Block 23	Other Coverage Code (OCC). Valid values are: 00 = Not specified, 01 = No other coverage, 02 = Other coverage exists - payment collected, 03 = Other coverage exists - claim not covered, 04 = Other coverage exists - payment not collected, 05 = Managed Care plan denial, 06 = other coverage denied - not a participating provider, 07 = Other coverage exists - not in effect on date of service (DOS), 08 = Claim is being billed for co-pay.
Block 24	Enter the dollar amount paid by the primary payer if other coverage applies (e.g., 2199/09 = $2,199.09).

Block 25	Enter the usual and customary charge for the prescription. This field should include the dispensing fee. The last two positions of the field are for cents only (e.g., 199/09 = $199.99).
Block 26	Enter comments, if any (i.e., "For high cholesterol").
Block 27	Enter the pharmacy's name, address, and telephone number.
Block 28	Note the certification statement on the claim form, then sign and date the claim form.

Billing Instructions: Instructions for the Completion of the Health Insurance Claim Form CMS-1500 (02-12), as a Void Invoice

The Void Invoice is used to void a paid claim. Follow the instructions for the completion of the Health Insurance Claim Form, CMS-1500 (02-12), except for the locator indicated below.

Locator 22 **Medicaid Resubmission**

Code - Enter the 4-digit code identifying the reason for the submission of the void invoice.

1042	Original claim has multiple incorrect items
1044	Wrong provider identification number
1045	Wrong enrollee eligibility number
1046	Primary carrier has paid DMAS maximum allowance
1047	Duplicate payment was made
1048	Primary carrier has paid full charge
1051	Enrollee not my patient
1052	Miscellaneous
1060	Other insurance is available

Original Reference Number/ICN - Enter the claim reference number/ICN of the paid claim. This number may be obtained from the remittance voucher and is required to identify the claim to be voided. Only one claim can be voided on each CMS-1500 (02-12) submitted as a Void Invoice. (Each line under Locator 24 is one claim).

NOTE: ICNs can only be voided through the Virginia MMIS up to three years from the **date the claim was paid**. After three years, ICNs are purged from the Virginia MMIS and can no longer be voided through the Virginia MMIS. If an ICN is purged from the Virginia MMIS, the provider must send a refund check made payable to DMAS and include the following information:

- A cover letter on the provider's letterhead which includes the current address, contact name and phone number.

- An explanation about the refund.
- A copy of the remittance page(s) as it relates to the refund check amount.

Mail all information to:
Department of Medical Assistance Services
Attn: Fiscal & Procurement Division, Cashier
600 East Broad St. Suite 1300
Richmond, VA 23219

Billing Instructions: Group Practice Billing Functionality

Providers defined in this manual are not eligible to submit claims as a Group Practice with the Virginia Medicaid Program. Group Practice claim submissions are reserved for independently enrolled fee-for-service healthcare practitioners (physicians, podiatrists, psychologists, etc.) that share the same Federal Employer Identification Number. Facility based organizations (NPI Type 2) and providers assigned an Atypical Provider Identifier (API) may not utilize group billing functionality.

Medicare Crossover: If Medicare requires you to submit claims identifying an individual Rendering Provider, DMAS will use the Billing Provider NPI to adjudicate the Medicare Crossover Claim. You will not enroll your organization as a Group Practice with Virginia Medicaid.

For more information on Group Practice enrollment and claim submissions using the CMS1500 (02-12), please refer to the appropriate practitioner Provider Manual found at https://www.virginiamedicaid.dmas.virginia.gov/wps/portal.

Billing Instructions: Negative Balance Information

Negative balances occur when one or more of the following situations have occurred:

- Provider submitted adjustment/void request
- DMAS completed adjustment/void
- Audits
- Cost settlements
- Repayment of advance payments made to the provider by DMAS

In the remittance process the amount of the negative balance may be either off set by the total of the approved claims for payment leaving a reduced payment amount or may result in a negative balance to be carried forward. The remittance will show the amount as, “less the negative balance” and it may also show “the negative balance to be carried forward”.

The negative balance will appear on subsequent remittances until it is satisfied. An example is if the claims processed during the week resulted in approved allowances of $1000.00 and the provider has a negative balance of $2000.00 a check will not be issued, and the remaining $1000.00 outstanding to DMAS will carry forward to the next remittance.

Billing Instructions: Special Billing Instructions -- Client Medical Management Program

The primary care provider (PCP) and any other provider who is part of the PCP'S CMM Affiliation Group bills for services in the usual manner, but other physicians must follow special billing instructions to receive payment. (Affiliation Groups are explained in Chapter 1 under CMM.) Other physicians must indicate a PCP referral or an emergency unless the service is excluded from the requirement for a referral. Excluded services are listed in Chapter I.

All services should be coordinated with the primary health care provider whose name is provided at the time of verification of eligibility. The CMM PCP referral does not override Medicaid service limitations. All DMAS requirements for reimbursement, such as preauthorization, still apply as indicated in each provider manual.

When treating a restricted enrollee, a physician covering for the primary care provider or on referral from the primary care provider must place the primary care provider's NPI in locator 17b or the API in Locator 17a with the qualifier '1D'and attach a copy of the Practitioner Referral Form (DMAS-70) to the invoice. The name of the referring PCP must be entered in locator 17.

In a medical emergency situation, if the practitioner rendering treatment is not the primary care physician, he or she must certify that a medical emergency exists for payment to be made. The provider must enter a "Y" in Locator 24C and attach an explanation of the nature of the emergency.

LOCATOR SPECIAL INSTRUCTIONS

10d Write "ATTACHMENT" for the Practitioner Referral Form, DMAS-70.

17 Enter the name of the referring primary care provider.

17a When a restricted enrollee is treated on referral from the primary physician, **red shaded** enter the qualifier '1D' and the appropriate provider number (current Medicaid or an API) (as indicated on the DMAS-70 referral form) and attach a copy of the Practitioner Referral Form to the invoice. Write "ATTACHMENT" in Locator 10d.

> **Note:** Please refer to the time line for the appropriate provider number as indicated in main instruction above.

17b When a restricted enrollee is treated on referral from the primary physician, **open** enter the NPI number (as indicated on the DMAS-70 referral form) and attach a copy of the Practitioner Referral Form to the invoice. Write "ATTACHMENT" in Locator 10d.

> **Note:** This locator can only be used for claims received on or after March 26, 2007.

24C When a restricted enrollee is treated in an emergency situation by a provider other than

the primary physician, the non-designated physician enters a “Y” in this Locator and explains the nature of the emergency in an attachment. Write “ATTACHMENT” in Locator 10d.

Billing Instructions: EDI Billing (Electronic Claims)

Please refer to X-12 Standard Transactions & our Companion Guides that are listed in the chapter.

Special Billing Instructions: Health Departments (Drugs, Family Planning and Nutritional Supplements)

Tuberculosis Oral Drugs
Health Department clinics should bill for all drugs using the unlisted HCPCS code J8499. Modifier U2 must be used in Block 24-D of the CMS-1500 (02-12) claim form. Clinics bill Medicaid with their actual cost for the drugs. If no modifier is billed, the claim may be denied. The qualifier ‘N4’ should be in locator 24 red shaded line followed by the NDC of the J code listed in 24D.

Family Planning Drugs and Devices
Birth control pills must be billed using code J8499 along with modifiers FP and U2 in Block 24-D of the CMS-1500 (02-12) claim form. The qualifier ‘N4’ should be in locator 24 red shaded line followed by the NDC of the J code listed in 24D.

Family planning supplies (such as condoms, Intrauterine Devices, etc.) should be billed using unlisted supply code 99070 with the FP and U2 modifiers. Actual costs for the drugs and supplies should be reflected in the charges. Claims submitted without the modifiers may be denied.

Nutritional Supplements
Nutritional Supplements should be billed using the national HCPCS codes for Enteral and Parenteral Therapy (B4000-B9999) with the U2 modifier in Block 24-D of the CMS-1500 (02-12) claim form. Actual cost for the supplements should be billed. If no modifier is billed, the claim may be denied.

Billing Instructions: Instructions for Completing the Paper CMS-1500 (02-12) Form for Medicare and Medicare Advantage Plan Deductible, Coinsurance and Copay Payments for Professional Services (Effective 11/02/2014)

The Direct Data Entry (DDE) Crossover Part B claim form is on the Virginia Medicaid Web Portal. Please note that providers are encouraged to use DDE for submission of claims that cannot be submitted electronically to DMAS. Registration thru the Virginia Medicaid Web Portal is required to access and use DDE. The DDE User Guide, tutorial and FAQ’s can be accessed from our web portal at: www.virginiamedicaid.dmas.virginia.gov. To access the DDE system, select the Provider Resources tab and then select Claims Direct Data Entry (DDE). Providers have the ability to create a

new initial claim, as well as an adjustment or a void through the DDE process. The status of the claim(s) submitted can be checked the next business day if claims were submitted by 5pm. DDE is provided at no cost to the provider. Paper claim submissions should only be submitted when requested specifically by DMAS.

Purpose:	A method of billing Medicare's deductible, coinsurance and copay for professional services received by a Medicaid member in the Virginia Medicaid program on the CMS 1500 (02-12) paper claim form. The CMS1500 (02-12) claim form must be used to bill for services received by a Medicaid member in the Virginia Medicaid program. The following instructions have numbered items corresponding to fields on the CMS1500 (02-12)
NOTE:	Note changes in locator 11c and 24A lines 1-6 red shaded area. These changes are specific to Medicare Part B billing only.

Locator	**Instructions**	
1	**REQUIRED**	**Enter an "X" in the MEDICAID box for the Medicaid Program. Enter an "X" in the OTHER box for Temporary Detention Order (TDO) or Emergency Custody Order (ECO).**
1a	**REQUIRED**	**Insured's I.D. Number** - Enter the 12-digit Virginia Medicaid Identification number for the member receiving the service.
2	**REQUIRED**	**Patient's Name** - Enter the name of the member receiving the service.
3	NOT REQUIRED	Patient's Birth Date
4	NOT REQUIRED	Insured's Name
5	NOT REQUIRED	Patient's Address
6	NOT REQUIRED	Patient Relationship to Insured
7	NOT REQUIRED	Insured's Address
8	NOT REQUIRED	Reserved for NUCC Use
9	NOT REQUIRED	Other Insured's Name
9a	NOT REQUIRED	Other Insured's Policy or Group Number
9b	NOT REQUIRED	Reserved for NUCC Use
9c	NOT REQUIRED	Reserved for NUCC Use
9d	NOT REQUIRED	Insurance Plan Name or Program Name
10	**REQUIRED**	**Is Patient's Condition Related To:** - Enter an "X" in the appropriate box. a. Employment? b. Auto accident c. Other Accident? (This includes schools, stores, assaults, etc.) NOTE: The state should be entered if known.
10d	Conditional	**Claim Codes (Designated by NUCC)** Enter "ATTACHMENT" if documents are attached to the claim form. **Medicare/Medicare Advantage Plan EOB should be attached.**
11	NOT REQUIRED	Insured's Policy Number or FECA Number
11a	NOT REQUIRED	Insured's Date of Birth
11b	NOT REQUIRED	Other Claim ID
11c	**REQUIRED**	**Insurance Plan or Program Name** Enter the word '**CROSSOVER**' **IMPORTANT: DO NOT** enter 'HMO COPAY' when billing for Medicare/Medicare Advantage Plan copays! Only enter the word **'CROSSOVER'**
11d	**REQUIRED** **If Applicable**	**Is There Another Health Benefit Plan?** If Medicare/Medicare Advantage Plan and Medicaid only, check "NO". Only check "Yes", if there is additional insurance coverage **other than** Medicare/Medicare Advantage Plan and Medicaid.
12	NOT REQUIRED	Patient's or Authorized Person's Signature
13	NOT REQUIRED	Insured's or Authorized Person's Signature
14	NOT REQUIRED	Date of Current Illness, Injury, or Pregnancy Enter date MM DD YY format Enter Qualifier 431 – Onset of Current Symptoms or Illness
15	NOT REQUIRED	Other Date
16	NOT REQUIRED	Dates Patient Unable to Work in Current Occupation
17	NOT REQUIRED	Name of Referring Physician or Other Source – Enter the name of the referring physician.
17a shaded red	NOT REQUIRED	I.D. Number of Referring Physician - The '1D' qualifier is required when the Atypical Provider Identifier (API) is entered. The qualifier 'ZZ' may be entered if the provider taxonomy code is needed to adjudicate the claim. Refer to the Medicaid Provider manual for special Billing Instructions for specific services.
17b	NOT REQUIRED	I.D. Number of Referring Physician - Enter the National Provider Identifier of the referring physician.
18	NOT REQUIRED	Hospitalization Dates Related to Current Services

<table>
<tr><td>19</td><td>NOT REQUIRED</td><td>Additional Claim Information
Enter the CLIA #.</td></tr>
<tr><td>20</td><td>NOT REQUIRED</td><td>Outside Lab?</td></tr>
<tr><td>21 A-L</td><td>REQUIRED</td><td>Diagnosis or Nature of Illness or Injury - Enter the appropriate ICD diagnosis code, which describes the nature of the illness or injury for which the service was rendered in locator 24E. Note: Line ‘A’ field should be the Primary/Admitting diagnosis followed by the next highest level of specificity in lines B-L.
Note: ICD Ind. Not required at this time.</td></tr>
<tr><td>22</td><td>REQUIRED
If Applicable</td><td>Resubmission Code – Original Reference Number. Required for adjustment or void. Enter one of the following resubmission codes for an adjustment:
<table>
<tr><th>Code</th><th>Description</th></tr>
<tr><td>1023</td><td>Primary Carrier has made additional payment</td></tr>
<tr><td>1024</td><td>Primary Carrier has denied payment</td></tr>
<tr><td>1025</td><td>Accommodation charge correction</td></tr>
<tr><td>1026</td><td>Patient payment amount changed</td></tr>
<tr><td>1027</td><td>Correcting service periods</td></tr>
<tr><td>1028</td><td>Correcting procedure/ service code</td></tr>
<tr><td>1029</td><td>Correcting diagnosis code</td></tr>
<tr><td>1030</td><td>Correcting charge</td></tr>
<tr><td>1031</td><td>Correcting units/visits/studies/procedures</td></tr>
<tr><td>1032</td><td>IC reconsideration of allowance, documented</td></tr>
<tr><td>1033</td><td>Correcting admitting, referring, prescribing, provider identification number</td></tr>
<tr><td>1053</td><td>Adjustment reason is in the Misc. Category</td></tr>
</table>
Enter one of the following resubmission codes for a void:
<table>
<tr><th>Code</th><th>Description</th></tr>
<tr><td>1042</td><td>Original claim has multiple incorrect items</td></tr>
<tr><td>1044</td><td>Wrong provider identification number</td></tr>
<tr><td>1045</td><td>Wrong enrollee eligibility number</td></tr>
<tr><td>1046</td><td>Primary carrier has paid DMAS maximum allowance</td></tr>
<tr><td>1047</td><td>Duplicate payment was made</td></tr>
<tr><td>1048</td><td>Primary carrier has paid full charge</td></tr>
<tr><td>1051</td><td>Enrollee not my patient</td></tr>
<tr><td>1052</td><td>Miscellaneous</td></tr>
<tr><td>1060</td><td>Other insurance is available</td></tr>
</table>
Original Reference Number - Enter the claim reference number/ICN of the Virginia Medicaid paid claim. This number may be obtained from the remittance voucher and is required to identify the claim to be adjusted or voided. Only one paid claim can be adjusted or voided on each CMS-1500 (02-12) claim form. (Each line under Locator 24 is one claim).
NOTE: ICNs can only be adjusted or voided through the Virginia MMIS up to three years from the date the claim was paid. After three years, ICNs are purged from the Virginia MMIS and can no longer be adjusted or voided through the Virginia MMIS. If an ICN is purged from the Virginia MMIS, the provider must send a refund check made payable to DMAS and include the following information:
• A cover letter on the provider’s letterhead which includes the current address, contact name and phone number.
• An explanation about the refund.
• A copy of the remittance page(s) as it relates to the refund check amount.
• Mail all information to:
Department of Medical Assistance Services
Attn: Fiscal & Procurement
Division Cashier
600 East Broad St, Suite 1300
Richmond, VA 23219</td></tr>
<tr><td>23</td><td>REQUIRED
If Applicable</td><td>Prior Authorization (PA) Number – Enter the PA number for approved services that require a service authorization.
NOTE: The locators 24A thru 24J have been divided into open and shaded line areas. The shaded area is ONLY for supplemental information. DMAS has given instructions for the supplemental information that is required when needed for DMAS claims processing. <u>ENTER REQUIRED INFORMATION ONLY.</u></td></tr>
<tr><td>24A lines 1-6 open area</td><td>REQUIRED</td><td>Dates of Service - Enter the from and thru dates in a 2-digit format for the month, day and year (e.g., 01 01 14).</td></tr>
</table>

24A-H lines 1- 6 red shaded	**REQUIRED If Applicable**	**NEW INFORMATION! DMAS is requiring the use of the following qualifiers in the red shaded for Part B billing:** **• A1 = Deductible (Example: A120.00) = $20.00 ded** **• A2 = Coinsurance (Example: A240.00) = $40.00 coins** **• A7= Copay (Example: A735.00) = $35.00 copay** **• AB= Allowed by Medicare/Medicare Advantage Plan (Example AB145.10) = $145.10 Allowed Amount** **• MA= Amount Paid by Medicare/Medicare Advantage Plan (Example MA27.08) see details below** **• CM= Other insurance payment (not Medicare/Medicare Advantage Plan) if applicable (Example CM27.08) see details below** **• N4 = National Drug Code (NDC)+Unit of Measurement** **'MA'**: This qualifier is to be used to show **Medicare/Medicare Advantage Plan's** payment. The 'MA' qualifier is to be followed by the dollar/cents amount of the payment by Medicare/Medicare Advantage Plan Example: Payment by Medicare/Medicare Advantage Plan is $27.08; enter **MA27.08** in the red shaded area '**CM**': This qualifier is to be used to show the amount paid by the insurance carrier **other than Medicare/Medicare Advantage plan**. The '**CM**' qualifier is to be followed by the dollar/cents amount of the payment by the other insurance. Example: Payment by the other insurance plan is $27.08; enter **CM27.08** in the red shaded area NOTE: No spaces are allowed between the qualifier and dollars. No $ symbol is allowed. The decimal between dollars and cents is required. **DMAS is requiring the use of the qualifier 'N4'**. This qualifier is to be used for the National Drug Code (NDC) whenever a drug related HCPCS code is submitted in 24D to DMAS. The Unit of Measurement Qualifiers must follow the NDC number. The unit of measurement qualifier code is followed by the metric decimal quantity or unit. Do not enter a space between the unit of measurement qualifier and NDC. Example: N400026064871UN1.0 **Any spaces unused for the quantity should be left blank.** **Unit of Measurement Qualifier Codes:** **• F2 – International Units** **• GR – Gram** **• ML – Milliliter** **• UN – Unit** **Examples of NDC quantities for various dosage forms as follows:** **a. Tablets/Capsules – bill per UN** **b. Oral Liquids – bill per ML** **c. Reconstituted (or liquids) injections – bill per ML** **d. Non-reconstituted injections (I.E. vial of Rocephin powder) – bill as UN (1 vial = 1 unit)** **e. Creams, ointments, topical powders – bill per GR** **f. Inhalers – bill per GR** **Note: All supplemental information entered in locator 24A thru 24H is to be left justified.** **Examples:** 1. **Deductible is $10.00, Medicare/Medicare Advantage Plan Allowed Amt is $20.00, Medicare/Medicare Advantage Plan Paid Amt is $16.00, Coinsurance is $4.00.** - **Enter:A110.00 AB20.00 MA16.00 A24.00** 2. **Copay is $35.00, Medicare/Medicare Advantage Plan Paid Amt is $0.00 Medicare/Medicare Advantage Plan Allowed Amt is $100.00** - **Enter: A735.00 MA0.00 AB100.00** 3. **Medicare/Medicare Advantage Plan Paid Amt is $10.00, Other Insurance payment is $10.00, Medicare/Medicare Advantage Plan Allowed Amt is $10.00, Coinsurance is $5.00, NDC is 12345678911, Unit of measure is 2 grams** - **Enter: MA10.00 CM10.00 AB10.00 A25.00 N412345678911GR2** ****Allow a space in between each qualifier set****
24B open area	**REQUIRED**	**Place of Service** - Enter the 2-digit CMS code, which describes where the services were rendered.
24C open area	**REQUIRED If applicable**	**Emergency Indicator** - Enter either 'Y' for YES or leave blank. **DMAS will not accept any other indicators for this locator.**
24D open area	**REQUIRED**	**Procedures, Services or Supplies – CPT/HCPCS –** Enter the CPT/HCPCS code that describes the procedure rendered or the service provided. **Modifier** - Enter the appropriate CPT/HCPCS modifiers if applicable.
24E open area	**REQUIRED**	**Diagnosis Code -** Enter the diagnosis code reference letter A-L (pointer) as shown in Locator 21 to relate the date of service and the procedure performed to the primary diagnosis. The primary diagnosis code reference letter for each service should be listed first. **NOTE: A maximum of 4 diagnosis code reference letter pointers should be entered.** Claims with values other than A-L in Locator 24-E or blank will be denied.
24F open area	**REQUIRED**	Charges - Enter the Medicare/Medicare Advantage Plan billed amount for the procedure/services. **NOTE: Enter the Medicare/Medicare Advantage Plan Copay amount as the charged amount when billing for the Medicare/Medicare Advantage Plan Copay ONLY.**
24G open area	**REQUIRED**	**Days or Unit -** Enter the number of times the procedure, service, or item was provided during the service period.
24H open area	**REQUIRED If applicable**	**EPSDT or Family Planning -** Enter the appropriate indicator. Required only for EPSDT or family planning services. 1 - Early and Periodic, Screening, Diagnosis and Treatment Program Services 2 - Family Planning Service
24I open	**REQUIRED If applicable**	**NPI –** This is to identify that it is a NPI that is in locator 24J
24 I redshaded	**REQUIRED If applicable**	**ID QUALIFIER –**The qualifier 'ZZ' can be entered to identify the provider taxonomy code if the NPI is entered in locator 24J open line. The qualifier '1D' is required for the API entered in locator 24J red shaded line.
24J open	**REQUIRED If applicable**	**Rendering provider ID# -** Enter the 10 digit NPI number for the provider that performed/rendered the care.
24J redshaded	**REQUIRED If applicable**	**Rendering provider ID# -** If the qualifier '1D' is entered in 24I shaded area enter the API in this locator. If the qualifier 'ZZ' was entered in 24I shaded area enter the provider taxonomy code if the NPI is entered in locator 24J open line.
25	NOT REQUIRED	Federal Tax I.D. Number
26	**REQUIRED**	**Patient's Account Number –** Up to FOURTEEN alphanumeric characters are acceptable.
27	NOT REQUIRED	Accept Assignment
28	**REQUIRED**	**Total Charge -** Enter the total charges for the services in 24F lines 1-6

29	**REQUIRED If applicable**	**Amount Paid –** For personal care and waiver services only – enter the patient pay amount that is due from the patient. **NOTE:** The patient pay amount is taken from services billed on 24A - line 1. If multiple services are provided on same date of service, then another form must be completed since only one line can be submitted if patient pay is to be considered in the processing of this service.
30	NOT REQUIRED	Rsvd for NUCC Use
31	**REQUIRED**	**Signature of Physician or Supplier Including Degrees or Credentials -** The provider or agent must sign and date the invoice in this block.
32	**REQUIRED If applicable**	**Service Facility Location Information –** Enter the name as first line, address as second line, city, state and 9 digit zip code as third line for the location where the services were rendered. **NOTE:** For physician with multiple office locations, the specific Zip code must reflect the office location where services given. Do NOT use commas, periods or other punctuations in the address. Enter space between city and state. Include the hyphen for the 9 digit zip code.
32a open	**REQUIRED If applicable**	**NPI # -** Enter the 10 digit NPI number of the service location.
32b red shaded	**REQUIRED If applicable**	**Other ID#: -** The qualifier '1D' is required with the API entered in this locator. The qualifier of 'ZZ' is required with the provider taxonomy code if the NPI is entered in locator 32a open line.
33	**REQUIRED**	**Billing Provider Info and PH # -** Enter the billing name as first line, address as second line, city, state and 9-digit zip code as third line. This locator is to identify the provider that is requesting to be paid. NOTE: Do NOT use commas, periods or other punctuations in the address. Enter space between city and state. Include the hyphen for the 9 digit zip code. The phone number is to be entered in the area to the right of the field title. Do not use hyphen or space as separator within the telephone number.
33a open	**REQUIRED**	**NPI –** Enter the 10 digit NPI number of the billing provider.
33b red shaded	**REQUIRED If applicable**	**Other Billing ID -** The qualifier '1D' is required with the API entered in this locator. The qualifier 'ZZ' is required with the provider taxonomy code if the NPI is entered in locator 33a open line. **NOTE: DO NOT** use commas, periods, space, hyphens or other punctuations between the qualifier and the number. The information may be typed (recommend font Sans Serif 12) or legibly handwritten. Retain a copy for the office files. Mail the completed claims to: Department of Medical Assistance Services CMS Crossover P. O. Box 27444 Richmond, Virginia 23261-7444

The information may be typed (recommend font Sans Serif 12) or legibly handwritten. Retain a copy for the office files.
Mail the completed claims to:

Department of Medical Assistance Services
CMS Crossover
P. O. Box 27444
Richmond, Virginia 23261-7444

Invoice Processing (PP)

The Medicaid invoice processing system utilizes a sophisticated electronic system to process Medicaid claims. Once a claim has been received, imaged, assigned a crossreference number, and entered into the system, it is placed in one of the following categories:

- Remittance Voucher
- **Approved** - Payment is approved or Pended. Pended claims are placed in a pended status for manual adjudication (the provider must not resubmit).
- **Denied** - Payment cannot be approved because of the reason stated on the remittance voucher.
- **Pend** – Payment is pended for claim to be manually reviewed by DMAS staff or waiting on further information from provider.
- **NO RESPONSE -** if one of the above responses has not been received within 30 days, the

provider should assume non-delivery and rebill using a new invoice form.

The provider's failure to follow up on these situations does not warrant individual or additional consideration for late billing.

Please use this link to search for DMAS Forms:
https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderFormsSearch